

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0018580</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Selfhelp Home of Chicago</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/2003</u> to <u>09/30/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>908 W. Argyle Road</u> <u>Chicago</u> <u>60640</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(773) 271-0300</u> Fax # <u>(773) 271-0633</u>		(Type or Print Name) _____	
IDPA ID Number: <u>362521053001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>01/01/57</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code <u>501(C)(3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>30</u>	Skilled (SNF)	<u>30</u>	<u>10,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>35</u>	Intermediate (ICF)	<u>35</u>	<u>12,810</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,790</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>305</u>	<u>1,881</u>	<u>2,256</u>	<u>4,442</u>	8
9	SNF/PED					9
10	ICF	<u>3,194</u>	<u>13,987</u>		<u>17,181</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,499</u>	<u>15,868</u>	<u>2,256</u>	<u>21,623</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.89%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 30 and days of care provided 2,256Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 09/30/2004 Fiscal Year: 09/30/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	254,562		12,480	267,042		267,042		267,042		1
2	Food Purchase		243,885		243,885		243,885	(8,946)	234,939		2
3	Housekeeping	106,818	27,394		134,212		134,212		134,212		3
4	Laundry		30,514		30,514		30,514		30,514		4
5	Heat and Other Utilities			78,292	78,292		78,292		78,292		5
6	Maintenance	77,032		87,958	164,990		164,990	65,488	230,478		6
7	Other (specify):*										7
8	TOTAL General Services	438,412	301,793	178,730	918,935		918,935	56,542	975,477		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,393,196	113,428	1,600	1,508,224		1,508,224		1,508,224		10
10a	Therapy			173,667	173,667		173,667		173,667		10a
11	Activities	108,537	13,477	1,996	124,010		124,010		124,010		11
12	Social Services			1,660	1,660		1,660		1,660		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,501,733	126,905	178,923	1,807,561		1,807,561		1,807,561		16
	C. General Administration										
17	Administrative	75,275			75,275		75,275		75,275		17
18	Directors Fees										18
19	Professional Services			40,892	40,892		40,892	(1,999)	38,893		19
20	Dues, Fees, Subscriptions & Promotions			6,953	6,953		6,953	407	7,360		20
21	Clerical & General Office Expenses	180,821	9,343	14,114	204,278		204,278	(14,387)	189,891		21
22	Employee Benefits & Payroll Taxes			371,814	371,814		371,814		371,814		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,125	1,125		1,125		1,125		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,517	40,517		40,517		40,517		26
27	Other (specify):*										27
28	TOTAL General Administration	256,096	9,343	475,415	740,854		740,854	(15,979)	724,875		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,196,241	438,041	833,068	3,467,350		3,467,350	40,563	3,507,913		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Selfhelp Home of Chicago

#0018580

Report Period Beginning:

10/01/2003

Ending:

09/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			87,765	87,765		87,765	32,990	120,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,806	1,806		1,806	(1,806)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			54,180	54,180		54,180	(54,180)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			143,751	143,751		143,751	(22,996)	120,755			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,848	286	91,134		91,134		91,134			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		211		211		211		211			41
42	Provider Participation Fee			35,686	35,686		35,686		35,686			42
43	Other (specify):* Nonallowable Costs	8,228		49,799	58,027		58,027	(58,027)				43
44	TOTAL Special Cost Centers	8,228	91,059	85,771	185,058		185,058	(58,027)	127,031			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,204,469	529,100	1,062,590	3,796,159		3,796,159	(40,460)	3,755,699			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(8,946)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(82,951)	30		9
10 Interest and Other Investment Income	(1,806)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(1,999)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(27,847)	43		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(44,160)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,709)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	127,249		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 127,249		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (40,460)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp Home of Chicago

Provider #: 0018580

10/01/2003 to 09/30/2004

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Schedule V Reference
Disallow Outreach Program	(154)	43
Disallow Gift Shop Purchases	(5,666)	43
Disallow Marketing Salaries	(8,228)	43
Disallow Support Collateral	(171)	43
Disallow Part A Lab	(9,523)	43
Disallow Part A X-ray	(5,859)	43
Disallow Web Site	(579)	43
Miscellaneous Income Offset	(13,980)	21
TOTAL	\$ (44,160)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/2003

Ending:

09/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				The Selfhelp Home		
				Inc.-Center Division	Chicago	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Maintenance	\$	The Selfhelp Home, Inc.-Center Division	0.00%	\$ 65,488	\$ 65,488	1
2	V	30 Depreciation		The Selfhelp Home, Inc.-Center Division	0.00%	115,941	115,941	2
3	V	34 Rent	54,180	The Selfhelp Home, Inc.-Center Division	0.00%		(54,180)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 54,180			\$ 181,429	\$ * 127,249	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/2003 Ending: 09/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See Attached Schedule 7A										3
4											4
5			No compensation or fees were paid to the Board of Directors								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp Home of Chicago

Provider #: 0018580

10/01/2003 to 09/30/2004

Schedule 7A

First Name	Last Name	Title	Function
Herbert	Roth	President	Board Member
Rolf	Weil	Imm. Past President	Board Member
Gerald	Franks	First Vice-President	Board Member
Bernard H.	Baum	Vice President	Board Member
M. Jay	Heilbrunn	Vice President	Board Member
Austin	Hirsch	Vice President	Board Member
Leni	Weil	Treasurer	Board Member
Steven	Loewenthal	Assistant Treasurer	Board Member
Henry	Straus	Secretary	Board Member
Jack	Bierig	Director	Board Member
Richard	Eggner	Director	Board Member
Peter	Glaser	Director	Board Member
Richard	Greenthal	Director	Board Member
Robert	Hoffmann	Director	Board Member
Suzanne	Kach	Director	Board Member
Gary	Kahn	Director	Board Member
Kurt B.	Karmin	Director	Board Member
Helen	Levy	Director	Board Member
Martha	Loewenthal	Director	Board Member
Stephen	Nechtow	Director	Board Member
Barbara	Passman	Director	Board Member
Michael	Ries	Director	Board Member
George	Rosenbaum	Director	Board Member
Howard	Sharfman	Director	Board Member
Daniel	Wolf	Director	Board Member
Judith	Wolf	Director	Board Member

See Accountants' Compilation Report

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/2003 Ending: 9/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9				N/A					9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/2003

Ending:

09/30/2004**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10								Miscellaneous interest expense			1,806	10	
11								Interest income offset			(1,806)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Selfhelp Home of Chicago**# **0018580** Report Period Beginning: **10/01/2003** Ending: **09/30/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																
1. Real Estate Tax accrual used on 2003 report.		\$	1																													
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$	3																													
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ N/A	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td></td><td>8</td></tr> <tr><td>2000</td><td></td><td>9</td></tr> <tr><td>2001</td><td>N/A</td><td>10</td></tr> <tr><td>2002</td><td></td><td>11</td></tr> <tr><td>2003</td><td></td><td>12</td></tr> </table>	1999		8	2000		9	2001	N/A	10	2002		11	2003		12	<table border="1"> <tr><td></td><td>FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999		8																														
2000		9																														
2001	N/A	10																														
2002		11																														
2003		12																														
	FOR OHF USE ONLY																															
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Selfhelp Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018580

CONTACT PERSON REGARDING THIS REPORT Mr. Marvin Rubin

TELEPHONE (773) 271-0300 FAX #: (773) 271-0633

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u>N/A</u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,944
 B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel
 Number of Stories 3

C. Does the Operating Entity?
 (a) Own the Facility
 (X) (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (X) (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

The Selfhelp Home, Inc.; retirement facility; 92 apartments; square footage of 80, 832

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 (X) NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	70,000	1970	\$ 191,769	1
2					2
3	TOTALS	70,000		\$ 191,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/2003

Ending:

09/30/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65	1974	1974	\$ 822,760	\$	50	\$ 16,455	\$ 16,455	\$ 485,428
5									
6									
7									
8									
Improvement Type**									
9	Security System	1980	786			15			786
10	Security System	1981	29,527			15			29,527
11	Building Improvements	1981	808			20			808
12	Building Improvements	1982	2,642			15			2,642
13	Building Improvements	1983	2,717			10			2,717
14	Building Improvements	1986	1,212			10			1,212
15	Building Improvements	1987	3,000			10			3,000
16	Building Improvements	1988	6,752			10			6,752
17	Building Improvements	1989	30,538			10			30,538
18	Building Improvement	1990	10,425			10			10,425
19	Building Improvements	1991	9,690			10			9,690
20	Building Improvements	1992	22,014			10			22,014
21	Building Improvements	1992	932			7			932
22	Building Improvements	1993	14,166			10			14,166
23	Building Improvements	1993	183			7			183
24	Building Improvements	1994	27,620			10	1,381	1,381	27,620
25	Building Improvements	1994	3,836			5			3,836
26	Building Improvements	1994	5,148			7			5,148
27	Building Improvements	1995	18,411			10	1,841	1,841	17,490
28	Building Improvements	1995	363			7			363
29	Building Improvements	1995	176,882	8,844		20	8,844		84,018
30	Building Improvements	1995	15,209			5			15,209
31	Building Improvements	1994	33,000			5			33,000
32	Fence	1996	6,704	202		20	335	133	2,687
33	Decorating	1996	5,905	136		20	295	159	2,060
34	Blacktop Resurfacing	1996	1,646	50		20	82	32	656
35	Security Camera	1996	895	26		20	45	19	354
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Boiler repairs	1996	\$ 5,914	\$ 158	20	\$ 296	\$ 138	\$ 2,368	37	
38	Emergency call system	1996	14,557	58	20	728	670	5,824	38	
39	Cabinets & vanities	1997	2,938	34	20	147	113	1,011	39	
40	Fire Alarms	1997	12,818	486	20	641	155	4,885	40	
41	Elevator Improvements	1997	6,171	98	20	309	211	2,114	41	
42	Ceiling	1997	563		20	28	28	224	42	
43	Tubing and piping	1997	1,667	19	20	83	64	655	43	
44	Faucets	1997	999		20	50	50	400	44	
45	Flooring	1997	2,152	80	20	108	28	824	45	
46	Air Conditioning	1997	1,505		20	75	75	600	46	
47	Doors	1997	7,523	214	20	376	162	2,901	47	
48	Cement Work	1997	1,275	32	20	64	32	496	48	
49	Windows	1997	51,709		20	2,585	2,585	20,680	49	
50	Outdoor Sprinklers	1997	2,573	64	20	129	65	999	50	
51	Bathtub & Toilet	1997	605		20	30	30	240	51	
52	Tuckpointing	1997	4,583		20	229	229	1,832	52	
53	Blinds	1997	1,255	63	20	63		472	53	
54	Boiler	1997	1,097		20	55	55	440	54	
55	Office Refurbishing	1997	908	33	20	45	12	344	55	
56	Compressor and Base Board	1997	680		20	34	34	272	56	
57	Fire Alarms	1998	20,992	524	20	1,050	526	7,087	57	
58	Sound System	1998	862		20	43	43	681	58	
59	Architect	1998	43,360	2,112	20	2,168	56	14,119	59	
60	Windows	1998	4,588		20	229	229	1,603	60	
61	Lights	1998	1,517		20	76	76	532	61	
62	Kitchen Sink	1998	1,230	62	20	62	(1)	403	62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 1,447,812	\$ 13,295		\$ 38,980	\$ 25,685	\$ 885,267	70	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,447,812	\$ 13,295		\$ 38,980	\$ 25,685	\$ 885,267	1
2	Doors & Locks	1998	685		20	34	34	238	2
3	Audio/Visual System	1998	10,578	264	20	529	265	3,571	3
4	Wall/Windows	1998	2,222	62	20	111	49	746	4
5	Cabinets & Vanities	1998	1,300		20	65	65	455	5
6	Electrical Work	1998	11,441	284	20	572	288	3,862	6
7	Heating & Cooling	1998	9,470	236	20	474	238	3,199	7
8	Roof	1998	8,333		20	417	417	2,919	8
9	Floor Coverings	1998	3,067		20	153	153	1,071	9
10	Computer Wiring	1998	6,242	312	20	312		2,028	10
11	Handrails & Grab Bars	1998	6,020	301	20	301		1,957	11
12	Lights	1999	1,217		20	60	60	330	12
13	Floor Coverings	1999	4,564		20	228	228	1,254	13
14	Heating & Cooling	1999	1,373		20	68	68	374	14
15	Elevator	1999	37,272	194	20	1,864	1,670	10,252	15
16	Cabinets	1999	2,251		20	112	112	616	16
17	Wall	1999	2,790		20	140	140	770	17
18	Fire Alarm	1999	14,911	658	20	746	88	4,103	18
19	Roof	1999	35,283	160	20	1,597	1,437	9,034	19
20	Call/Paging System	1999	5,142	164	20	258	94	1,419	20
21	Pipes & Faucet	1999	865		20	44	44	242	21
22	Room Conversion	1999	3,169		20	158	158	869	22
23	Fire Ducts	1999	35,113	1,756	20	1,756		9,658	23
24	Security System	1999	13,503	676	20	676		3,718	24
25	Electrical Wiring	1999	20,805	1,040	20	1,040		5,720	25
26	Architect	1999	540	28	20	28		154	26
27	Blinds	2000	1,050		20	53	53	265	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,687,018	\$ 19,430		\$ 50,775	\$ 31,345	\$ 954,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/2003 Ending: 09/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,687,018	\$ 19,430		\$ 50,775	\$ 31,345	\$ 954,091	1
2	Cabinets	2000	3,135	23	20	134	111	670	2
3	Lobby Renovation	2000	3,397		20	170	170	850	3
4	Dining Room Renovation	2000	7,818	38	20	353	315	1,765	4
5	Washroom Renovation	2000	1,039		20	52	52	260	5
6	Light Fixtures	1999	893		20	45	45	225	6
7	Room Conversion	2000	673		20	34	34	170	7
8	Closet/Coat Room	2000	205		20	10	10	50	8
9	Doors	2000	1,568	5	20	73	68	365	9
10	Tiles	1999	140		20	7	7	35	10
11	Air Conditioner	2000	90		20	4	4	20	11
12	Resident Call System	2000	14,103	394	20	394		1,970	12
13	Heating & Cooling	2000	838		20	42	42	210	13
14	Ceiling Fan	1999	287		20	14	14	70	14
15	Dining Room Window	2001	1,834		20	92	92	322	15
16	Code Alert System	2001	2,501		20	125	125	437	16
17	Shower Temperature Control	2001	1,797	90	20	90		315	17
18	Call Station Living Room	2001	3,015	150	20	151	1	528	18
19	Doorknobs	2001	2,866		20	144	144	504	19
20	Repaving	2001	8,381		20	419	419	1,467	20
21	Fence	2001	784		20	40	40	140	21
22	Key Pad Locks	2001	776		20	39	39	136	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392	33,115	20	22,520	(10,595)	78,820	23
24	Elevator- Steel Frame	2001	533	54	20	27	(27)	67	24
25	Hot Water Tank	2001	2,070	98	20	104	6	260	25
26	Feed Pump	2001	2,300	230	20	115	(115)	288	26
27	Coils & Drains	2002	8,650	866	20	216	(650)	648	27
28	Boiler	2001	3,375	338	20	169	(169)	422	28
29	Carpeting	2002	28,345	1,418	20	1,417	(1)	3,543	29
30	Compressor	2002	3,375	338	20	169	(169)	422	30
31	Motorized Dampers	2002	18,547	928	20	927	(1)	2,318	31
32	Smoke Detectors and Duct Work	2002	9,644	482	20	482	0	1,205	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,270,389	\$ 57,997		\$ 79,353	\$ 21,356	\$ 1,052,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward		\$ 2,270,389	\$ 57,997		\$ 79,353	\$ 21,356	\$ 1,052,593		1
2	Stock ceiling tile	2003	260	10	20	13	3	20		2
3	Heaters	2003	6,082	250	20	304	54	456		3
4	8th floor cabinets	2003	1,593	80	20	80	(0)	120		4
5	Water pump	2003	6,917	168	20	346	178	519		5
6	Replace 2 motors	2003	634	64	20	32	(32)	48		6
7	Exhaust fan	2003	925		20	46	46	69		7
8	Duct work	2003	7,202	250	20	360	110	540		8
9	Pipes changed	2003	1,300	130	20	65	(65)	98		9
10	Water heaters and water tank	2003	13,335	1,332	20	667	(665)	1,000		10
11	Vanities	2003	319		20	16	16	24		11
12	Carpeting	2003	2,623		20	131	131	197		12
13	Compressor	2003	12,306	862	20	615	(247)	923		13
14	1st floor hallway 930 bld	2003	1,101		20	55	55	83		14
15	Refridge pressure, safety valve, & mixer	2003	1,056	52	20	53	1	79		15
16	A/C and temperature control	2003	2,359	134	20	118	(16)	173		16
17	Locks and keypads	2003	1,234	26	20	62	36	97		17
18	Elevator	2003	8,143		20	407	407	611		18
19	Solarium	2003	143,632	8,292	20	7,182	(1,110)	10,773		19
20	Dampers	2003	7,680	192	20	192		192		20
21	Exhaust fan	2003	6,093	152	20	152	0	152		21
22	Bathroom work	2003	894	22	20	22		22		22
23	Water Pump & motor	2003	6,850	171	20	171		171		23
24	Entrance door	2003	1,474	37	20	37		37		24
25	Heaters	2004	10,988	275	20	275		275		25
26	Duct work	2004	3,111	78	20	78		78		26
27	Air handler	2004	3,845	96	20	96		96		27
28	Blower	2004	1,423	36	20	36		36		28
29	Blinds	2004	4,811	120	20	120		120		29
30	Pressure valve	2004	1,334	33	20	33		33		30
31	8th floor remodeling - oxygen room	2004	15,415	385	20	385		385		31
32	Condensor	2004	18,531	463	20	463		463		32
33	Cooling system	2004	2,695	67	20	67		67		33
34	TOTAL (lines 1 thru 33)		\$ 2,566,554	\$ 71,775		\$ 92,032	\$ 20,257	\$ 1,070,551		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/2003

Ending:

09/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 419,249	\$ 15,164	\$ 27,897	\$ 12,733	5-7 yrs	\$ 251,323	71
72	Current Year Purchases	11,560	826	826	(0)	5-7 yrs	826	72
73	Fully Depreciated Assets	93,675					93,675	73
74								74
75	TOTALS	\$ 524,484	\$ 15,990	\$ 28,723	\$ 12,733		\$ 345,824	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78				N/A						78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,282,807	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,765	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,755	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 32,990	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,416,375	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ **N/A** Description:

(Attach a schedule detailing the breakdown of movable equipment)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	N/A	17
18					18
19					19
20					20
21	TOTAL		\$		21

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	8,011	\$ 76,107	\$	8,011	\$ 76,107	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		17	3,364		17	3,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,836	94,196		8,836	94,196	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				80,683		80,683	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A				2	286	10,165	2	10,451	13
14	TOTAL			\$	16,867	\$ 173,953	\$ 90,848	16,867	\$ 264,801	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp Home of Chicago

Provider #: 0018580

10/01/2003 to 09/30/2004

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Part A Supplies	L39, C2			10,009
Ambulance	L39, C3	2	286	
Durable Medical Supplies	L39, C2			156
Total		2	286	10,165

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 305,127	\$ 305,127	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0)	187,335	187,335	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,000	6,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	525,193	525,193	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,023,655	\$ 1,023,655	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost		822,760	14
15	Leasehold Improvements, at Historical Cost	1,513,268	1,743,794	15
16	Equipment, at Historical Cost	305,078	524,484	16
17	Accumulated Depreciation (book methods)	(624,988)	(1,416,375)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,193,358	\$ 1,866,432	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,217,013	\$ 2,890,087	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 117,384	\$ 117,384	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,739	64,739	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,671	4,671	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	74,592	74,592	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 261,386	\$ 261,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Schedule 17A	30,824	30,824	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 30,824	\$ 30,824	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 292,210	\$ 292,210	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,924,803	\$ 2,597,877	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,217,013	\$ 2,890,087	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2004

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	After	
	Operating	Consolidation
Bequest Receivable	523,400	523,400
Scholarship Loan Receivable	6,000	6,000
Scholarship Loan Payable	(4,207)	(4,207)
Total Line 9 - Other Current Assets (specify):	525,193	525,193

Other Current Liabilities (specify):	After	
	Operating	Consolidation
Deferred Retirement Plan	66,085	66,085
Current Maturity Retirement Plan	6,000	6,000
Accrued Expenses	2,507	2,507
Total Line 36 - Other Current Liabilities (specify):	74,592	74,592

Other Long-Term Liabilities (specify):	After	
	Operating	Consolidation
Interco A/C-Ries Fund	(75,624)	(75,624)
Interco A/C-Bonem Fund	29,577	29,577
Interco A/C-Scholarship	11,581	11,581
Interco A/C-Marx Fund	65,290	65,290
Total Line 43 - Other Long-Term Liabilities (specify):	30,824	30,824

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,198,987	1
2	Restatements (describe):		2
3			3
4	Cumulative activity of funds other than healthcare facility	(2,279,270)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (80,283)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,005,086	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,005,086	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,924,803	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/2003

Ending: 09/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,358,900	1
2	Discounts and Allowances for all Levels	(3,361)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,355,539	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	13,402	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,533	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	101,671	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,606	23
	D. Non-Operating Revenue		
24	Contributions	2,301,881	24
25	Interest and Other Investment Income***	1,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,303,857	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Guest Apartment	3,850	28
28a	Miscellaneous Income	21,393	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,801,245	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	918,935	31
32	Health Care	1,807,561	32
33	General Administration	740,854	33
	B. Capital Expense		
34	Ownership	143,751	34
	C. Ancillary Expense		
35	Special Cost Centers	149,372	35
36	Provider Participation Fee	35,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,796,159	40
41	Income before Income Taxes (line 30 minus line 40)**	2,005,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,005,086	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
Tax Exempt Organization

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/2003

Ending:

09/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,000	2,040	\$ 75,746	\$ 37.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,334	23,183	557,713	24.06	3
4	Licensed Practical Nurses	6,089	7,004	124,596	17.79	4
5	Nurse Aides & Orderlies	63,088	71,962	635,141	8.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,763	9,859	108,537	11.01	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,166	2,360	33,367	14.14	13
14	Head Cook	5,975	6,505	80,375	12.36	14
15	Cook Helpers/Assistants	19,793	21,549	140,820	6.53	15
16	Dishwashers					16
17	Maintenance Workers	6,602	6,875	77,032	11.20	17
18	Housekeepers	12,159	14,166	106,818	7.54	18
19	Laundry					19
20	Administrator	1,593	1,593	63,230	39.69	20
21	Assistant Administrator	736	736	12,045	16.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,205	8,978	180,821	20.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	322	322	8,228	25.55	33
34	TOTAL (lines 1 - 33)	157,825	177,132	\$ 2,204,469 *	\$ 12.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	272	\$ 12,480	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	40	1,600	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	37	1,996	L11, C3	44
45	Social Service Consultant	32	1,660	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	381	\$ 17,736		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	N/A		51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/2003

Ending: 09/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Linda Liss Fine	Administrator	0%	36,884	Workers' Compensation Insurance	72,148	IDPH License Fee	
Marvin Rubin	Administrator	0%	26,346	Unemployment Compensation Insurance	6,177	Advertising: Employee Recruitment	
Barbara Snower	Asst. Admin	0%	12,045	FICA Taxes	169,323	Health Care Worker Background Check (Indicate # of checks performed <u>33</u>)	407
				Employee Health Insurance	105,757	Life Service Network	3,248
				Employee Meals		Illinois Council on Long-Term Care	3,705
				Illinois Municipal Retirement Fund (IMRF)* Retirement Plan	18,409		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,275				
B. Administrative - Other							
Description			Amount				
N/A							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount
Sachnoff & Weaver	Legal	2,866				Out-of-State Travel	
Martin Brand	Accounting	1,240					
American Express TBS	Accounting	3,170				In-State Travel	
Altschuler, Melvoin,& Glasser LLP	Accounting	23,562	N/A				
Omnicare	Computer Consulting	3,330					
Paychex	Payroll Services	6,724				Seminar Expense	1,125
						Entertainment Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,892	TOTAL		(agree to Sch. V, line 24, col. 8)	
						TOTAL	1,125

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Selfhelp Home of Chicago

Provider #: 0018580

10/01/2003 to 09/30/2004

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule XIX, Professional Services) 40,892

Out-of-period legal expenses (1,999)

Total (agree to Schedule V, line 19, column 8) 38,893

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9						N/A							
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

STATE OF ILLINOIS

0018580

Report Period Beginning: 10/01/2003

Page 23

Ending: 09/30/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$3,248; IL Council \$3,705
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 72,761 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 35,686
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,946
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit Currently in Progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		254,562	0	12,480	267,042	0	267,042	0	267,042
2. Food Purchase		0	243,885	0	243,885	0	243,885	-8,946	234,939
3. Housekeeping-		106,818	27,394	0	134,212	0	134,212	0	134,212
	4	0	30,514	0	30,514	0	30,514	0	30,514
5. Heat and Other Utilities		0	0	78,292	78,292	0	78,292	0	78,292
6. Maintenance-		77,032	0	87,958	164,990	0	164,990	65,488	230,478
7. *		0	0	0	0	0	0	0	0
8. Total General Services		438,412	301,793	178,730	918,935	0	918,935	56,542	975,477
	9	0	0	0	0	0	0	0	0
10. Nursing & Medical Records-		1,393,196	113,428	1,600	1,508,224	0	1,508,224	0	1,508,224
10a. Therapy		0	0	173,667	173,667	0	173,667	0	173,667
11. Activities		108,537	13,477	1,996	124,010	0	124,010	0	124,010
	12	0	0	1,660	1,660	0	1,660	0	1,660
	13	0	0	0	0	0	0	0	0
	14	0	0	0	0	0	0	0	0
15. *		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		1,501,733	126,905	178,923	1,807,561	0	1,807,561	0	1,807,561
17. Administrative-		75,275	0	0	75,275	0	75,275	0	75,275
	18	0	0	0	0	0	0	0	0
19. Professional Services		0	0	40,892	40,892	0	40,892	-1,999	38,893
20. Fees, Subscriptions, & Promotio		0	0	6,953	6,953	0	6,953	407	7,360
21. Clerical & General Office-		180,821	9,343	14,114	204,278	0	204,278	-14,387	189,891
22. Employee Benefits & Payroll		0	0	371,814	371,814	0	371,814	0	371,814
	23	0	0	0	0	0	0	0	0
24. Travel & Seminar		0	0	1,125	1,125	0	1,125	0	1,125
	25	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice		0	0	40,517	40,517	0	40,517	0	40,517
27. *		0	0	0	0	0	0	0	0
28. Total General Adminis		256,096	9,343	475,415	740,854	0	740,854	-15,979	724,875
29. Total General Administrative		2,196,241	438,041	833,068	3,467,350	0	3,467,350	40,563	3,507,913
30. Depreciation		0	0	87,765	87,765	0	87,765	32,990	120,755
	31	0	0	0	0	0	0	0	0
32. Interest		0	0	1,806	1,806	0	1,806	-1,806	0
	33	0	0	0	0	0	0	0	0
34. Rent-Facility & Grounds		0	0	54,180	54,180	0	54,180	-54,180	0
	35	0	0	0	0	0	0	0	0
	36	0	0	0	0	0	0	0	0
37. Total Ownership		0	0	143,751	143,751	0	143,751	-22,996	120,755
	38	0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	90,848	286	91,134	0	91,134	0	91,134
	40	0	0	0	0	0	0	0	0
	41	0	211	0	211	0	211	0	211
	42	0	0	35,686	35,686	0	35,686	0	35,686
43. Other (specify):-		8,228	0	49,799	58,027	0	58,027	-58,027	0
44. Total Special Cost Ce		8,228	91,059	85,771	185,058	0	185,058	-58,027	127,031
45. Grand Total		2,204,469	529,100	1,062,590	3,796,159	0	3,796,159	-40,460	3,755,699

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	305,127	305,127
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	187,335	187,335
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	6,000	6,000
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	525,193	525,193
10. Total current assets	1,130,103	1,130,103
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	191,769
14. Buildings, at Historical Cost	0	822,760
15. Leasehold Improvements, Historical Cost	1,513,268	1,743,794
16. Equipment, at Historical Cost	305,078	524,484
17. Accumulated Depreciation (book methods)	-624,988	-1,416,375
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,193,358	1,866,432
25. Total Assets	2,323,461	2,996,535
CURRENT LIABILITIES		
26. Accounts Payable	117,384	117,384
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	64,739	64,739
31. Accrued Taxes Payable	4,671	4,671
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	74,592	74,592
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	261,386	261,386
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	30,824	30,824
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	30,824	30,824
46. Total Liabilities	292,210	292,210
47. Total Equity	1,305,921	2,704,325
48. Total Liabilities and Equity	1,598,131	2,996,535

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,358,900
2. Discounts and Allowances for all Levels	-3,361
Subtotal - Inpatient Care	3,355,539
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	13,402
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,533
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	101,671
22. Laundry	0
Subtotal - Other Operating Revenue	116,606
24. Contributions	2,301,881
25. Interest and Other Investments Income	1,976
Subtotal - Non-Operating Revenue	2,314,681
27. Other Revenue (specify):	27,008
28. Other Revenue (specify):	0
Subtotal - Other Revenue	27,008
30. Total Revenue	5,813,834
31. General Services	918,935
32. Health Care	1,807,561
33. General Administration	740,854
34. Ownership	143,751
35. Special Cost Centers	149,372
35. Provider Participation Fee	35,686
37. Other	0
40. Total Expenses	3,796,159
41. Income Before Income Taxes	2,017,675
42. Income Taxes	0
43. Net Income or Loss for the Year	2,017,675

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